S. No. 2
1—1-4-41
5-17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 6 1928

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr. 7.6403

State File No.

Registration District No. Primary Registration District No. 2000 Registrar's No. 177

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 34 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield,
(If outside city or town limits, write "RURAL")
(d) Street No. 2030 N. Glenstone
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country

3. (a) PRINT FULL NAME Sarah Lee Bridges Wheeler
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Charles W. Wheeler
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased October (Month) 20, (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
68	4	2	hr. min.

9. Birthplace Davies County, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation In Home
11. Industry or business

FATHER
12. Name James Bridges
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Elizabeth Stovall
15. Birthplace Unknown (City, town, or county) Unk no mo (State or foreign country)

16. (a) Informant Ralph Wheeler
(b) Address Springfield, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/43 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cemetery
18. (a) Signature of funeral director Alma Lohmeyer Funeral Home
(b) Address Springfield, Missouri
19. (a) 2-24-43 (Date received local registrar) (b) O. W. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 22nd year 1943 hour 5:30 minute A. M.
21. I hereby certify that I attended the deceased from Feb 1st 1943 to Feb 22 1943; that I last saw her alive on 2-22 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Chorleystitis	3 Wks.
Due to:	
Due to:	
Other conditions. (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) M.D.
Address [illegible] Date signed 2-24-43

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(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed..... E. D. Northey

Licensed Embalmer No..... 1767

P. O. Address..... Spring Lake

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.